

Medicaid Expansion: A Good Deal for Indian Country

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Montana has a unique opportunity to improve healthcare for American Indians by expanding Medicaid.¹ If Montana policymakers choose to take advantage of this opportunity, American Indians who are newly eligible for Medicaid, including those who rely on Indian Health Service (IHS) facilities, will see improvements in their healthcare. Up to 19,547 American Indians would be newly enrolled in the program,² improving access to care and health outcomes throughout Indian Country.

Furthermore, Medicaid expansion is a bargain for Montana. From 2014-2017, the federal government will pay 100% of the cost to expand Medicaid to low-income adults earning less than 138% of the federal poverty level, which is \$26,344 for a family of three.³ Beginning in 2017, Montana will pick up a small portion of the costs, paying no more than 10% from 2020 forward.⁴ In addition, any services billed by Indian Health Service to Medicaid for care of American Indians will continue to be reimbursed 100% by the federal government, eliminating *any* fiscal obligation by the state.⁵

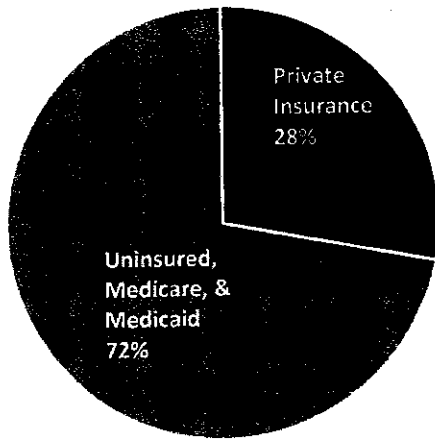
Lack of Access to Quality Health Care in Indian Country Is Unacceptable

Of 33 states with significant Native populations, Montana ranks the highest of any state in uninsured American Indians (40%) and the second lowest in number of American Indians with private insurance (28%) (Chart 1).⁶ Among American Indians ages 18-64 (the population affected by Medicaid expansion), 57% are currently uninsured (Chart 2).⁷ In contrast, Montana has the fourth highest number of American Indians who report having access to underfunded IHS clinics (68%).⁸

Key Points

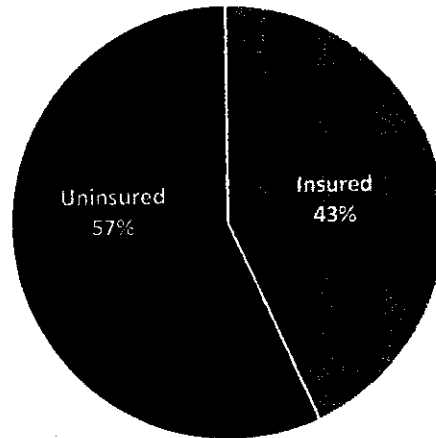
- Federal funding for Indian Health Service (IHS) covers only 60% of the demand for care.
- Due to a severe funding shortage, American Indians who rely on IHS often experience a lack of access to quality care, including preventative care and early treatment of chronic diseases.
- Underfunding for IHS is a contributing factor to the health disparities that exist between American Indians and the general population.
- Montana has a unique opportunity to expand Medicaid eligibility at little cost to the state. Under expanded eligibility, up to 19,547 American Indians would enroll in Medicaid and have expanded access to care.
- Because IHS clinics get reimbursed for care to Medicaid recipients, the expanded coverage would increase the capacity of those facilities to address funding shortages and provide improved services to all of their American Indian patients.
- The influx of new federal dollars created by Medicaid expansion will provide an economic boost throughout Montana.

Chart 1: Only 28% of American Indians in MT Are Covered by Private Insurance



Source: Fox and Boerner, 2012

Chart 2: Over Half of American Indians in MT Ages 18-64 Are Uninsured*



Source: Fox, 2011

*IHS is not considered health insurance.

History of Indian Health Service

During the 18th century, the federal government made agreements with American Indian and Alaska Native tribes in exchange for land and natural resource ownership. As part of these agreements, the federal government assumed responsibility for the provision of healthcare to American Indians.¹

The Snyder Act of 1921 made two key changes in Indian Country. It extended full U.S. citizenship to Native Americans and also authorized federal appropriations specifically for "the relief of distress and conservation of health... [and] for the employment of...physicians" for Indian tribes throughout the United States.² Almost 25 years later, under the 1955 Transfer Act, the Indian Health Service (IHS) was established. This establishment of IHS transferred responsibility for Indian health from military oversight to the Department of Health, Education, and Welfare.³

¹Brett Lee Shelton, "Legal and Historical Roots of Health Care for American Indians and Alaska Natives in the United States," Henry J. Kaiser Family Foundation, February 2004.

²The Snyder Act, November 2, 1921, P.L. 67-85.

³Carol Ingram, Shannon McMahon, & Veronica Guerra, "Implications of Health Reform for American Indian and Alaska Native Populations," Center for Healthcare Strategies and National Academy for State Health Policy, February 2012.

The Billings Area IHS Service Unit is responsible for the oversight of the Tribal Health programs in Montana and Wyoming, including IHS-run clinics, tribally administered programs, and urban Indian health clinics. In Montana, there are three hospitals that provide both inpatient and outpatient care, and ten health centers that provide solely outpatient care. Montana also has five Urban Indian Programs located in Billings, Great Falls, Helena, Missoula, and Butte.⁹

IHS clinics serve eligible American Indians regardless of insurance status. However, IHS has been severely underfunded historically, with current funding only covering 60% of the need.¹⁰ IHS expenditures per capita are roughly one-third the amount spent per capita for the general public and one-half the amount spent on federal prisoners.¹¹

Congress appropriates additional funds to IHS for high priority medical conditions that cannot be treated by existing IHS providers due to lack of capacity, available equipment, and/or professional expertise. These funds are referred to as Contract Health Services (CHS).¹² The range of applicable services may include hospital care, physician services, outpatient care, laboratory, dental, radiology, pharmacy, and transportation services. However, CHS funds appropriated are also insufficient to cover the demand. "[T]he amount of our annual appropriations is not sufficient to cover all referrals, resulting in some referrals being denied or deferred according to medical priorities," stated Dr. Yvette Roubideaux, IHS Director.¹³ Therefore, only individuals with extreme needs are given approval for specialty services, while other less severe cases are often denied.

In addition, there is significant need for the expansion or replacement of many clinic buildings.¹⁴ IHS funding does not go solely to health care services, but is also expected to cover facilities construction, maintenance, and improvement.¹⁵ As a result, IHS facilities and equipment are often overcrowded, outdated, and unreliable. Maintenance needs are backlogged. Laboratory and systems equipment have not kept pace with medical advancements, and facilities space has not kept up with increased user populations and demand.¹⁶

As a result of the severe funding shortages in Indian Health Services, American Indians continue to suffer serious health disparities, often because of lack of access to preventative health care and early treatment.¹⁷ In fact, the underfunding of IHS contributes to health disparities for American Indians in cancer,¹⁸ diabetes, and other preventable diseases.¹⁹

Medicaid Expansion Will Improve Access to Health Care in Indian Country

If Medicaid is expanded, up to 19,547 American Indians will be newly enrolled in the program.²⁰ This expanded coverage would not just expand access to health care for those recipients, but would also increase the capacity of Indian Health Services to meet the health care needs of American Indians more generally.²¹ Current and newly eligible American Indian Medicaid enrollees may continue to seek care from IHS-run, tribal, and urban Indian clinics. When a Medicaid recipient seeks services at such a clinic, IHS can seek reimbursements from Medicaid. These reimbursements free up IHS funds to increase and improve their core services.²² In addition, the demand for contract health service funds will decline, as patients newly covered by Medicaid can seek services outside of IHS without using limited CHS funds. The potential impact of these changes is far-reaching and will help provide tribal communities the means necessary to close the health disparity gap between American Indians and the general population.²³

Medicaid Expansion Will Spur Economic Growth in Indian Country and Throughout Montana

Expanding Medicaid will result in a significant influx of federal dollars into the state. These federal dollars will pay for medical care that wouldn't otherwise be provided or would be provided at state, local, or private expense. This funding will not only provide health care coverage, it will also help to create jobs in communities across Indian Country in Montana. Expanding Medicaid coverage will effectively increase demand for medical services, as newly covered individuals seek both preventative and critical care. This increased demand will allow medical facilities to purchase new equipment and supplies, hire more medical and support staff, and fund building renovations and new construction.²⁴ According to the Billings Area IHS Service Unit, it currently employs 54 physicians, 179 nurses, 29 dentists, and 33 pharmacists who provide services in various Montana and Wyoming communities.²⁵ These numbers would likely rise as the number of newly insured patients seeking treatment increases.

Conclusion

Medicaid expansion is an excellent opportunity for Montana. By participating, the state can provide health care coverage for tens of thousands of Montanans, including a large number of American Indians whose needs are not being adequately addressed in the current system. For Indian Country, expansion is a necessary step in the right direction to eradicate generations of the extreme health disparities affecting American Indian populations. Most of all, it is a commitment that will strengthen Montana's families, communities, and economy.

¹ In June 2012, the Supreme Court upheld major health care reform provisions of the Patient Protection and Affordable Care Act. However, the Court also ruled that it was up to the individual states to decide whether or not to expand Medicaid eligibility as outlined in the law. For more information on the Supreme Court decision, see the Henry J. Kaiser Family Foundation, "Focus on Health Reform: A Guide to the Supreme Court Decision on the ACA's Medicaid Expansion," August 2012.

² Ed Fox, "Health Care Reform: Tracking Tribal, Federal, and State Implementation." Kauffman & Associate, Inc., May 20, 2011.

³ The Federal Poverty Level (FPL) is currently \$19,090 for a family of three. <http://aspe.hhs.gov/poverty/12poverty.shtml/>. Health Reform specifies Medicaid expansion up to 133% of the FPL. However, 5% of income is disregarded, creating an effective eligibility level of 138% of FPL. Because children living at or below 138% of the federal poverty line are already eligible for Medicaid, the Medicaid expansion will only increase coverage for adults in the state. Currently, eligibility for Medicaid in Montana varies dramatically based on certain characteristics of the person applying. Eligibility limits for Medicaid and/or Healthy Montana Kids are:

- Children- 250% of the federal poverty level (FPL) or below;
- Pregnant women- 150% of FPL or below;
- Working parents- below 56% of FPL;
- Nonworking parents- below 34% of FPL;
- Adults without children- not eligible for Medicaid unless they are aged, blind or disabled.

Montana Department of Health and Human Services.

⁴ For more information about Medicaid expansion, see generally, Montana Budget and Policy Center, "Medicaid Expansion: A Good Deal for Montana," August 2012.

⁵ National Indian Health Board, "Medicaid Expansion under ACA for American Indians and Alaska Natives," April 14, 2011.

<http://www.nihb.org/docs/05212011/NIHB%20Issue%20Paper%20-%20Medicaid%20Expansion%20under%20ACA%20for%20AI-AN%20FINAL%202011-04-14.pdf>

⁶ Ed Fox and Verne' Boerner, "Health Care Reform: Measuring its Impact for American Indians & Alaska Natives in 33 States with HIS Funded Health Programs," September 24, 2012, [http://www.edfoxphd.com/33 States NIHB ACC draft presentation eif yfb092012.pdf](http://www.edfoxphd.com/33%20States%20NIHB%20ACC%20draft%20presentation%20eif%20yfb092012.pdf)

⁷ Ed Fox, "Health Care Reform: Tracking Tribal, Federal, and State Implementation." Kauffman & Associate, Inc., May 20, 2011.

⁸ Ed Fox and Verne' Boerner, "Health Care Reform: Measuring its Impact for American Indians & Alaska Natives in 33 States with HIS Funded Health Programs," September 24, 2012, [http://www.edfoxphd.com/33 States NIHB ACC draft presentation eif yfb092012.pdf](http://www.edfoxphd.com/33%20States%20NIHB%20ACC%20draft%20presentation%20eif%20yfb092012.pdf)

Note: In considering these numbers, it is important to note that the American Community Survey (ACS) data does not differentiate American Indian people that do and do not meet the federal definition of an American Indian, a requirement to be eligible for IHS services.

⁹ Montana Medicaid Program: Montana Department of Public Health and Human Services Report to the 2011 Legislature, State Fiscal Years 2009/2010," December 22, 2010, <http://www.dphhs.mt.gov/2011biennialreport/mtmedicaidreport.pdf>

¹⁰ The Urban Institute, "A National Roundtable on the Indian Health System & Medicaid Reform: Summary Report," October 5, 2005. See also, Indian Health Service, "Frequently Asked Questions," <http://www.ihs.gov/GeneralWeb/HelpCenter/Customerservices/FAQ/>, accessed Oct. 31, 2012.

¹¹ National Indian Health Board, "Health Care Reform: Indian Country Recommendations," May 31, 2009.

¹² Indian Health Service Fact Sheets, "Contract Health Services," January 2012, <http://www.ihs.gov/PublicAffairs/IHSBrochure/CHS.asp>.

¹³ Dr. Yvette Roubideaux, "Correcting The Record on Contract Health Services Program," *Indian Country Today*, November 17, 2011, http://indiancountrytodaymedianetwork.com/ict_sbc/correcting-the-record-on-the-contract-health-services-program#ixzz27cfwi1dX

¹⁴ Indian Health Service Fact Sheets, "Health Facilities Construction," January 2012, <http://www.ihs.gov/PublicAffairs/IHSBrochure/FcHtCnstr.asp>

¹⁵ Ed Fox, May 2011.

¹⁶ Indian Health Service Fact Sheets, "Health Facilities Construction," January 2012, <http://www.ihs.gov/PublicAffairs/IHSBrochure/FcHtCnstr.asp>

¹⁷ Donald Warne, MD, MPH, "Research and Educational Approaches to Reducing Health Disparities Among American Indians and Alaska Natives," *Journal of Transcultural Nursing* (July 2006), pp. 1-6.

¹⁸ Donald Warne, Judith Kaur, David Perdue, "American Indian/Alaska Native Cancer Policy: Systemic Approaches to Reducing Cancer Disparities," *Journal of Cancer Education* (April 2012) pp. 18-23, <http://rd.springer.com/article/10.1007/s13187-012-0315-6>

¹⁹ Donald Warne, July 2006.

²⁰ Ed Fox, May 2011.

²¹ In addition to Medicaid expansion, the ACA provides for the establishment of health insurance exchanges. The exchanges are beyond the scope of this report, but provide significant additional opportunities for improving the capacity of Indian Health Services and health outcomes in Indian Country more generally. See, Kris Locke & Mim Dixon, "Tribal Planning for Health Insurance Exchanges Begins Now," prepared for the Tribal Self-Governance Committee, March 14, 2011.

²² National Indian Health Board, "Medicaid Expansion under ACA for American Indians and Alaska Natives," April 14, 2011.

<http://www.nihb.org/docs/05212011/NIHB%20Issue%20Paper%20-%20Medicaid%20Expansion%20under%20ACA%20for%20AI-AN%20FINAL%202011-04-14.pdf>

²³ For more specific information on American Indian health disparities and detailed statistics see <http://www.ihs.gov/PublicAffairs/IHSBrochure/Disparities.asp>

²⁴ See generally, The Bureau of Business and Economic Research, "The Importance of Public Health Care Funding to the Montana Economy," University of Montana, December 2010.

²⁵ Letter from Pete Conway, Billings Area Indian Health Area Director, http://www.ihs.gov/billings/index.cfm?module=bao_main